

Child Health Innovation - strengthening Integrated Management of Childhood Illness (IMCI) implementation

Dr Deirdre Pansegrouw

Ilembe DCST Paediatrician

US Embassy Best Practices and Innovations workshop

03.11.17







IMCI tools and materials

Electronic

IMCI

Develop and test with phased implementation

Align with updated guidelines and simplify

Pamphlets:

- Healthy lifestyle
- HIV disclosure
- How to take ARVs
- Adherence and Virological failure

Paeds &

Patient education

adolescent HIV stationary

material

HIV Paediatric task team (KZN DOH):

- Step by Step guide for paediatric and adolescent HIV. KZN DOH intranet resource
- IMCI Chart Booklet updates: KZN 2017 adaption for KZN DOH intranet resource

Job aids:

- IMCI wall charts
- Recording forms

- IMCI wall charts updated/ created
- Public license
- KZN DOH intranet resource

Strengthen **IMCI** implementation

Update HIV component **Supervision**

3 day supervisors training

Supervision tools (DCSTs)

Training materials

- **PowerPoint** presentations created (3 day training)
- Used by RTC
- **KZN DOH intranet** resource



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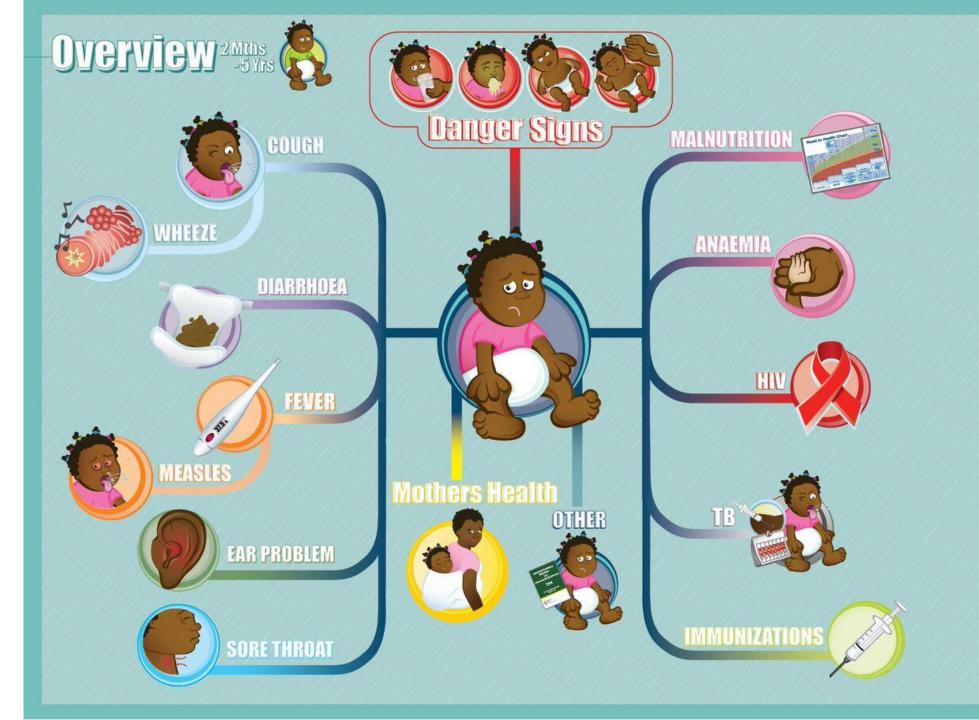
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SEVERE PNEUMONIA OF VERY SEVERE DISEASE

- ① Give Oxygen ② If wheeze, nebulise and reclassify
- ② If stridor, nebulise and give prednisone · ⊕ Give ceftriaxone · ⊕ Give cotrimoxazole











PNEUMONIA

- ① If wheeze, nebulise and reclassify ② Give amoxicillin ③>14 Days, exclude TB
- Soothe throat Advise on Immediate Return Follow-up





COUGH or COLD

① >14 Days, exclude TB ② Soothe throat ② Advise on Immediate Return ③ Follow-Up











RT INITION

STEP1 RECORD



STEP 2 GONFIRM



STEP 6 START ART





STEP 3 CAREGIVER ABLETO GIVEART



STEP 4 NURSE TO INITIATE ART

STEP 5 BASELINE RECORDING





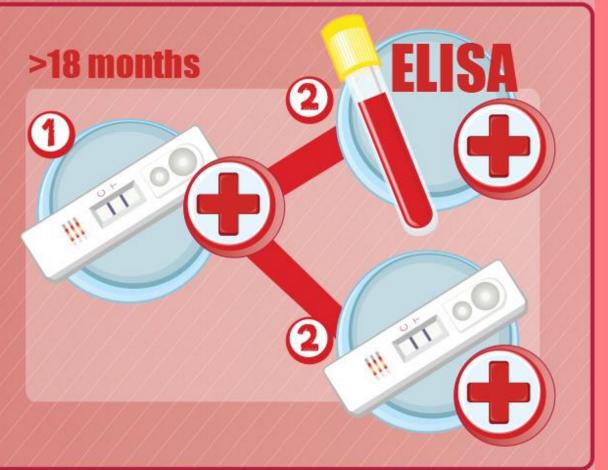


STEP 1 RECORD



STEP 2 GONFIRM





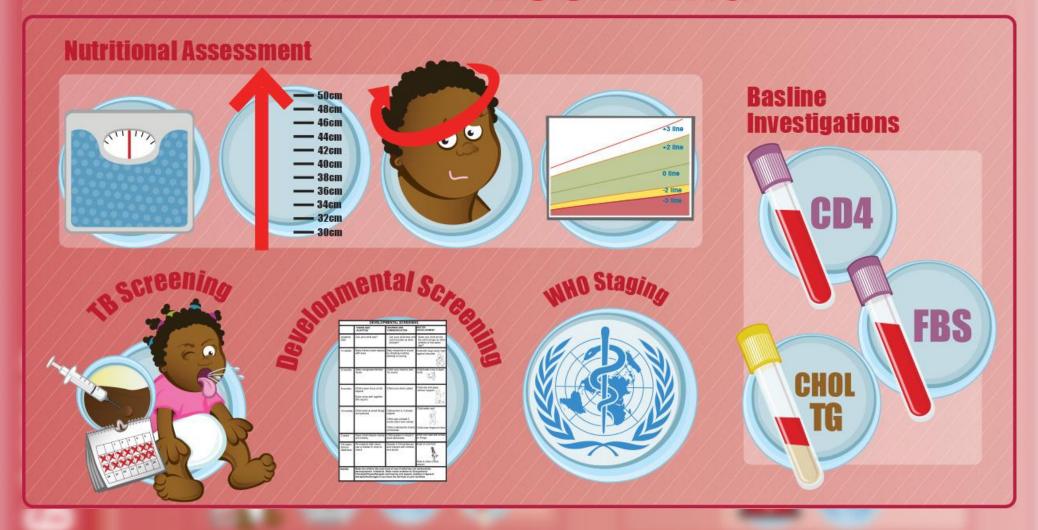
STEP 3 GRETO GIVEART



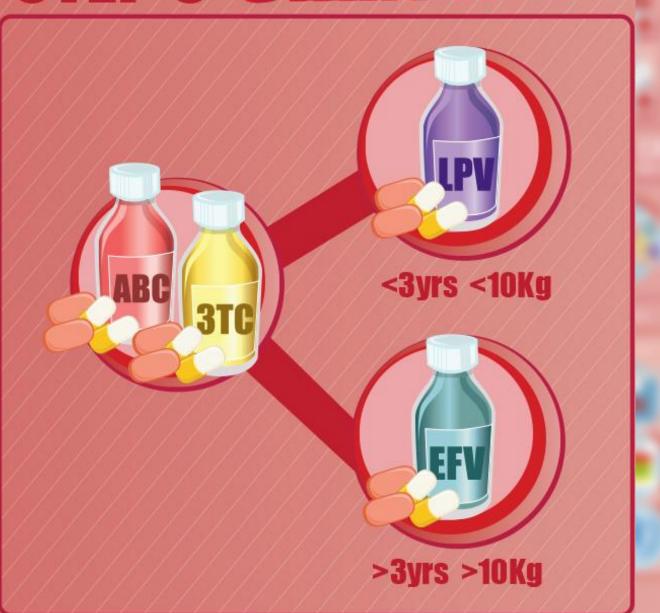
STEP 4 NURSE TO INITIATE ART



STEP 5 BASELINE RECORDING

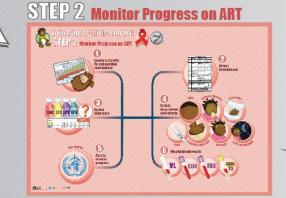


STEP 6 STARTART









STEP 3 Provide ART's

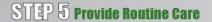






STEP 6 Counsel the Caregiver











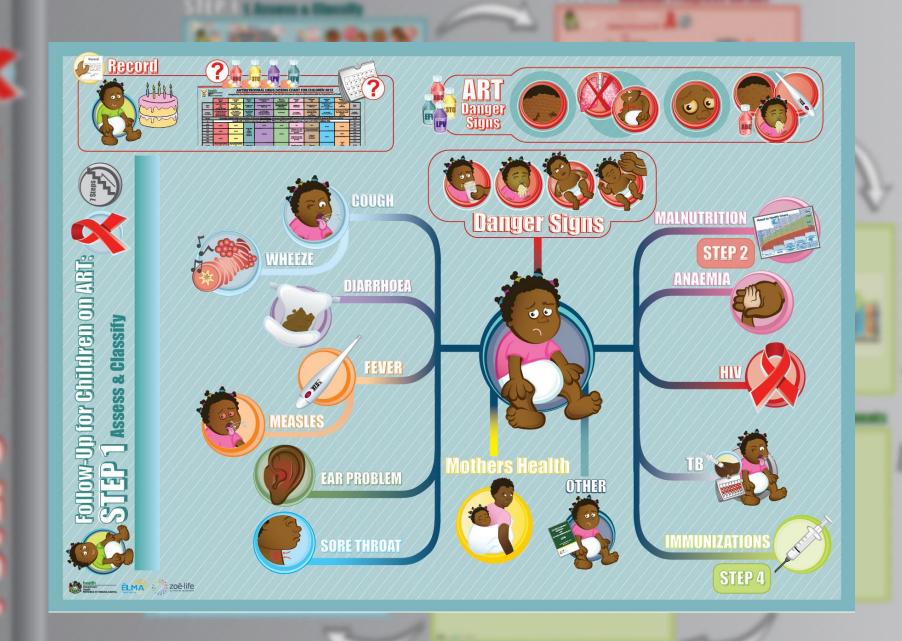


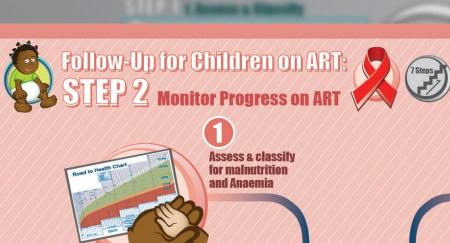








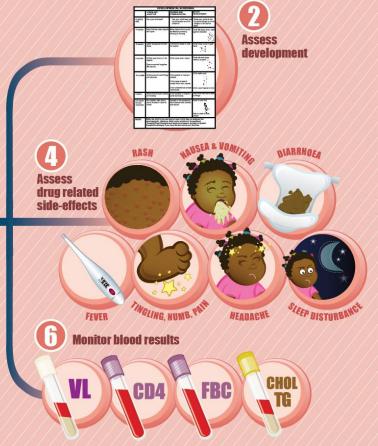








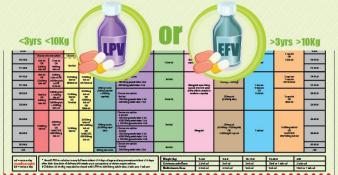














7 STEPS - HIV FOLLOW-U











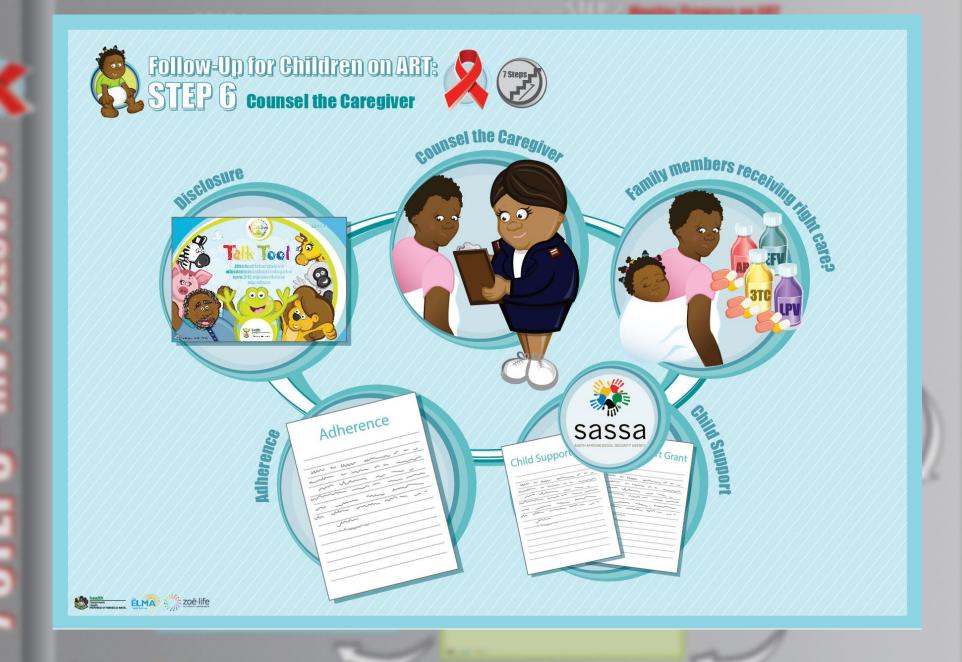






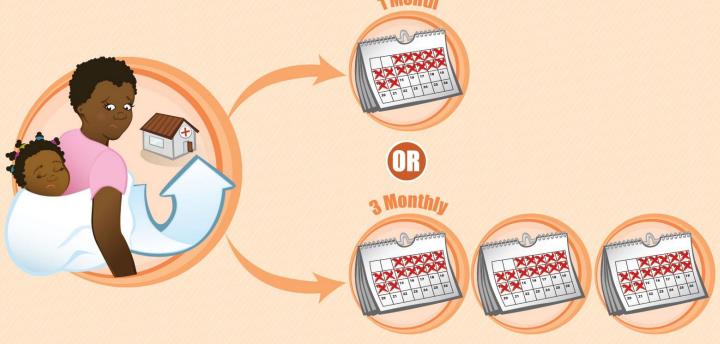








1 Access a Character





7 STEPS - HIV FOLLOW-U



IMCI recording forms

health Department: Health PROVINCE OF KWAZULU-NATAL	THS UP TO 5 YEARS
Name: Age: Weight: kg Temp: °C [What are the child's problems?	Date:Time: Initial visit Follow-up visit
CHECK FOR GENERAL DANGER SIGNS NOT ABLE TO DRINK OR BREASTFEED VOMITS EVERYTHING Yes No CONVULTIONS DURING THIS ILLNESS LETHARGIC OR UNCONSCIOUS	Always classify VERY SEVERE DISEASE
COUGH OR DIFFICULT BREATHING? For how long? days Counted breaths per minute Fast breathing SATS >90% in room air SATS >90% in room air SET SATS >90% in room air SET SATS SATS SATS SATS SATS SATS SATS	
DIARRHOEA? For how long? days Blood in the stool How much / what fluid has mother given: Diameter and the stool Sunken eyes Not able to drink / drinking poorly Drinking eagerly, thirsty Pinched abdomen skin goes back: Normally Slowly Very slowly (< 2 secs)	SEVERE DEHYDRATION (2 SIGNS) SOME DEHYDRATION (2 SIGNS) NO VISIBLE DEHYDRATION SEVERE PERSISTENT DIARRHOEA (>14 + DEH) PERSISTENT DIARRHOEA (>14 DAYS) SEVERE DYSENTERY (BLOOD + DEH) DYSENTERY (BLOOD) DEH DEHYDRATION
FEVER (by history or feel or 37.5°C or above)? For how long? days	SUSPECTED MENINGITIS FEVER OTHER CAUSE SUSPECTED SEVERE MALARIA MALARIA SUSPECTED MALARIA FEVER OTHER CAUSE
MEASLES? (SUB-SECTION FOR FEVER) Yes No	SUSPECTED COMPLICATED MEASLES MEASLES (JUST FOR FOLLOW UP IF RESULT IS POSITIVE) SUSPECTED MEASLES



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HIV FOLLOW UP 7 STEPS

(IMCI 2014 Participant Manual Module 9 p 315 - 331)









IMCI

BASIC INFORMATION ABOUT HIV

FIGURE 1.2. HOW HIV ATTACKS THE BODY

- **3.** Problems like **diarrhoea** try to **attack** our body, but CD4 fights them to **defend** the body.
- **4.** Now, **HIV enters** and starts to **attack** the CD4.









Scenario 24: Babalwa

On assessment now she is thin, but not wasted.

MUAC: 12cm. Wt: 7.2kg. Ht: 70cm. Tp: 37.5 °C.

There is no oedema of the feet. She is not pale, but has enlarged lymph glands in her neck and groin. Her parotid glands are very swollen, but not tender. She does not have thrush. You do a feeding assessment, but find that apart from a poor appetite there is no feeding problem.

- a) What does the weight curve on the RTHC show?
- b) Which features of HIV infection are present?
- c) What are your classifications? Please complete your IMCI recording form and include the treatments you would give.
- d) What other information would you like to have?

health
Department: Health PROVINCE OF KWAZULU-NATAL

CHILD AGE 2 MONTHS UP TO 5 YEARS

Name:Age:Age:	:Time:
What are the child's problems? <u>Insufficient weight gain</u>	☐ Initial visit ☐ Follow-up visit
CHECK FOR GENERAL DANGER SIGNS ■ Yes ■ CONVULTIONS DURING THIS ILLNESS ■ VOMITS EVERYTHING ■ LETHARGIC OR UNCONSCIOUS	Always classify VERY SEVERE DISEASE
COUGH OR DIFFICULT BREATHING? For how long? days Counted breaths per minute	SEVERE PNEUMONIA OR VERY SEVERE DISEASE PNEUMONIA COUGH OR COLD RECURRENT WHEEZE WHEEZE (FIRST EPISODE)
DIARRHOEA? For how long? days Blood in the stool How much / what fluid has mother given: Drinking eagerly, thirsty Pinched abdomen skin goes back: Yes No Seneral condition: (2 clinical signs) Lethargic or unconscious Restless or irritable Sunken eyes Not able to drink / drinking poorly Drinking eagerly, thirsty Normally Slowly Very slowly (< 2 secs)	SEVERE DEHYDRATION (2 SIGNS) SOME DEHYDRATION (2 SIGNS) NO VISIBLE DEHYDRATION SEVERE PERSISTENT DIARRHOEA (>14 + DEH) PERSISTENT DIARRHOEA (>14 DAYS) SEVERE DYSENTERY (BLOOD + DEH) DYSENTERY (BLOOD) DEH DEHYDRATION
FEVER (by history or feel or 37.5°C or above)? For how long? days Stiff neck Malaria Risk. If malaria risk: Malaria Test: Positive Negative GENERAL DANGER SIGNS	SUSPECTED MENINGITIS FEVER OTHER CAUSE SUSPECTED SEVERE MALARIA MALARIA SUSPECTED MALARIA FEVER OTHER CAUSE
MEASLES? (SUB-SECTION FOR FEVER) Fever Measles rash Runny nose or Cough or Red eyes Contact with measles Pneumonia Symptomatic HIV infection Cornea clouded Deep mouth ulcer Mouth ulcers Eyes draining pus	SUSPECTED COMPLICATED MEASLES MEASLES (JUST FOR FOLLOW UP IF RESULT IS POSITIVE) SUSPECTED MEASLES



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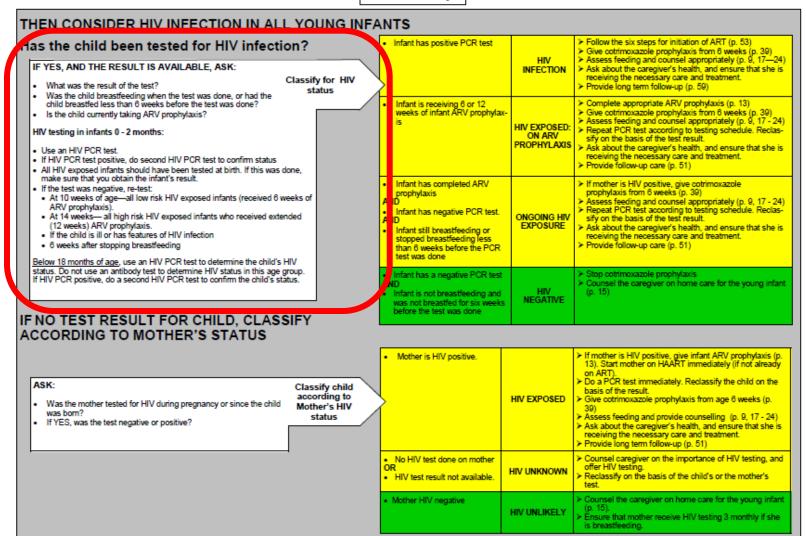


IMCI Chart Booklet p8

s the child been tested for HIV infection?	Infant has pos	itive PCR test		➤ Follow the six steps for initiation of ART (p. 53) ➤ Give cotrimoxazole prophylaxis from 8 weeks (p. 39)
F YES, AND THE RESULT IS AVAILABLE, ASK: What was the result of the test? Was the child breastfeeding when the test was done, or had the	ıv		HIV INFECTION	 Assess feeding and counsel appropriately (p. 9, 17—24 Ask about the caregiver's health, and ensure that she is receiving the necessary care and treatment. Provide long term follow-up (p. 59)
If HIV PCR test positive, do second HIV PCR test to confirm status If HIV PCR test positive, do second HIV PCR test to confirm status All HIV exposed infants should have been tested at birth. If this was done,	Infant is receiveeks of infancis	nt ÅRV prophylax-	HIV EXPOSED: ON ARV PROPHYLAXIS	 Complete appropriate ARV prophylaxis (p. 13) Give cotrimoxazole prophylaxis from 6 weeks (p. 39) Assess feeding and counsel appropriately (p. 9, 17 - 24) Repeat PCR test according to testing schedule. Reclassify on the basis of the test result. Ask about the caregiver's health, and ensure that she is receiving the necessary care and treatment. Provide follow-up care (p. 51)
make sure that you obtain the infant's result. If the test was negative, re-test: At 10 weeks of age—all low risk HIV exposed infants (received 6 weeks of ARV prophytaxis). At 14 weeks—all high risk HIV exposed infants who received extended (12 weeks) ARV prophylaxis. If the child is ill or has features of HIV infection weeks after stopping breastfeeding Below 18 months of age, use an HIV PCR test to determine the child's HIV	Infant has on prophylaxis AND Infant has neg AND Infant still bre stopped breat than 6 weeks test was done	gative PCR test. astfeeding or stfeeding less before the PCR	ONGOING HIV EXPOSURE	 If mother is HIV positive, give cotrimoxazole prophylaxis from 6 weeks (p. 39) Assess feeding and counsel appropriately (p. 9, 17 - 24) Repeat PCR test according to testing schedule. Reclassify on the basis of the test result. Ask about the caregiver's health, and ensure that she in receiving the necessary care and treatment. Provide follow-up care (p. 51)
tatus. Do not use an antibody test to determine HIV status in this age group. HIV PCR positive, do a second HIV PCR test to confirm the child's status. NO TEST RESULT FOR CHILD, CLASSIFY CORDING TO MOTHER'S STATUS		eastfeeding and tfed for six weeks	HIV NEGATIVE	 Stop cotrimoxazole prophylaxis Counsel the caregiver on home care for the young infa (p. 15)
ASK: Was the mother tested for HIV during pregnancy or since the child was born? If YES, was the test negative or positive? Classify chi according t Mother's HI status				 If mother is HIV positive, give infant ARV prophylaxis (p 13). Start mother on HAART immediately (if not already on ART). Do a PCR test immediately. Reclassify the child on the basis of the result. Give cotrimoxazole prophylaxis from age 6 weeks (p. 39) Assess feeding and provide counselling (p. 9, 17 - 24) Ask about the caregiver's health, and ensure that she is receiving the necessary care and treatment. Provide long term follow-up (p. 51)
	No HIV test do OR HIV test result	н	HIV UNKNOWN	 Counsel caregiver on the importance of HIV testing, an offer HIV testing. Reclassify on the basis of the child's or the mother's test.
	Mother HIV ne			> Counsel the caregiver on home care for the young infar



IMCI Chart Booklet p8





INITIATING ART IN CHILDREN: Follow the six steps

STEP 1: RECORD PATIENT DETAILS AND HISTORY

Record the following information in the Paediatric and Adolescent Stationary.

- Patient details.
- Caregiver details: Details of primary and secondary caregiver.
- Past medical history:
 - Allergies
 - Mode of transmission
 - ARVs prior to ART start date including PMTCT prophylaxis
 - ART transfer in details
 - Disclosure status
 - Immunization status (update from RTHB)
 - Past medical history including surgical history

STEP 2: DECIDE IF THE CHILD HAS CONFIRMED HIV INFECTION

Child <18 months:

HIV infection is confirmed if the first positive PCR test is confirmed with a second positive PCR test.

Proceed to Steps 3 - 6 whilst awaiting second PCR result. (i.e. initiate on basis of first PCR result but confirm with second result).

Child >18 months:

Two different rapid antibody tests are positive OR one rapid test and an ELISA (lab) test is positive

- If the first HIV test is positive and the second test is negative (discordant), REFER
- Send outstanding tests but proceed to step 3 while awaiting results.

All HIV-infected children are eligible for ART regardless of CD4 count and WHO stage, according to the Universal Test and Treat (UTT) guidelines.

STEP 3: DECIDE IF THE CAREGIVER IS ABLE TO GIVE ART

- Check that the caregiver is willing and able to administer ART.
- Complete psychosocial readiness and social record sections in the HIV clinical chart.
- The caregiver should ideally have disclosed the child's HIV status to another adult who can assist with providing ART (or be part of a support group).
- If caregiver is able to give ART, move to Step 4.
- If not, classify as HIV INFECTION not on ART. Work with the counsellors and social worker to initiate ART as soon as possible.
- If caregiver not willing or able to administer ART after consultation with the social worker and HIV counsellors, REFER.

IMCI Chart Booklet p53

STEP 4: TO DECIDE IF A IMCI NURSE SHOULD INITIATE ART

Check for the following:

- General danger signs or any severe classification
- Infant <1 month of age
- Child weighs less than 3 kg
- TB
- Fast breathing
- Any WHO stage 4 condition
- If any of these are present, refer to next level of care for ART initiation.
- If none present, move to Step 5.

STEP 5: ASSESS AND RECORD BASELINE INFORMATION

- Nutritional assessment:
 - Weight, height/ length, head circumference (if <2 years), MUAC.
 - BMI or WFH z-score. Classify based on findings.
- 2. Assess and classify for Anemia.
- TB screening and features.
- Developmental screening (use chart in addendum or RTHB).
- WHO clinical staging.
- Reproductive health.
- 7. Baseline laboratory investigations:
 - · CD4 count and Haemoglobin.
 - Cholesterol and Triglycerides (if on lopinavir/ritonavir).
 - ALT (if on nevirapine or TB treatment).
- If the child has SEVERE ACUTE MALNUTRITION, SEVERE ANAEMIA (Hb < 7g/dl) or TB refer to the next level of care for management and for initiation of ART.
- > If Hb is 7 g/dl 10 g/dl, classify as ANAEMIA and treat (p. 32). Do not delay starting ART.
- Send any outstanding laboratory tests. If the child already meets the criteria for starting ART, do not wait for the results before starting ART.

STEP 6: START ART

- If the child <3 years or weighs less than 10 kg, use regimen ABC, 3TC, LPV/r (p55-56).
- If the child is 3 years or older, and weighs 10 kg or more, use regimen ABC, 3TC, EFV (p57-58).
- Remember to give cotrimoxazole (p. 39).
- Give other routine treatments (p. 35).
- Follow-up after one week.

Note:

All children should be fast-tracked.

Record all information on the relevant Paediatric and Adolescent Stationary.



IMCI Chart Booklet p64

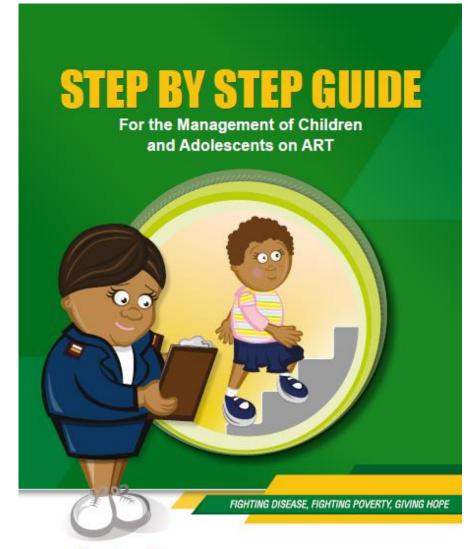
IDENTIFY SKIN PROBLEMS

> IF SKIN HAS BLISTERS/SORES/PUSTULES

LOOK	SIGNS	CLASSIFY	TREAT	FEATURES IN HIV INFECTION
	Mild fever preceding the rash. Rash begins on the trunk and face, later spreads to the arms and legs. Vesicles appear progressively over days and forms scabs after they rupture. Contagious from the fever starts until 6 days after the lesions have appeared/ all lesions have crusted. Usually lasts for about 1 week.	CHICKEN POX	 Limit contact with other children and pregnant women until all lesions have crusted. Ensure adequate hydration. Cut fingernails short and discourage scratching. Treat itching: Apply calamine lotion In severe cases, give an oral antihistamine: Chlorphenamine 0.1 mg/kg/dose 6–8 hourly (EDL p22.3. NB: only children >2 years). Refer urgently if severe rash or complications (e.g. pneumonia, jaundice, meningitis, myocarditis, hepatitis): Will need oral acyclovir 20 mg/kg/dose 6 hourly for 7 days (Doctor initiated. EDL p10.8). 	Atypical presentation in immuno-compromised children. May last longer. Complications like secondary bacterial infection, myocarditis, hepatitis, encephalitis, meningitis and pneumonia are more frequent. Chronic infection with continued appearance of new lesions for >1 month; Typical vesicles evolve into non-healing ulcers that become necrotic and crusted.
	Vesicles in one area on one side of body with intense pain or scars plus shooting pain. They are uncommon in children except when they are immune- compromised.	HERPES ZOSTER	Keep lesions clean and dry. Acyclovir 20 mg/kg 4 times daily for 7 days. If the eye or the tip of the nose is involved—REFER TO OPTHALMOLOGY. Give paracetamol for pain relief (p41). Follow up in 7 days. Refer if disseminated disease, involvement of the eye, pneumonia or suspected meningitis. Monitor for secondary bacterial infection.	 Duration of disease longer. Haemorrhagic vesicles, necrotic ulceration. Rarely recurrent, disseminated or multi-dermatomal. A clinical stage 2 defining disease (p54).
	Pustules and papules with honey-coloured crusts. Commonly starts on the face or buttocks, then spreads to the neck, hands, arms and legs.	IMPETIGO	 ➤ Good personal and household hygiene to avoid spread of infection. ➤ Wash and soak sores in soapy water to soften and remove crusts. ➤ Apply antiseptic 8 hourly: Povidone iodine 5% cream or 10% ointment. ➤ Drain pus if fluctuant. ➤ Give antibiotic if extensive lesions: Cephalexin, oral, 12-25mg/kg/dose 6 hourly (EDL p22.2) OR: Flucloxacillin, oral, 500mg 6 hourly (EDL p22.4). ➤ Refer urgently if child has fever and or if infection extends to the muscles. 	



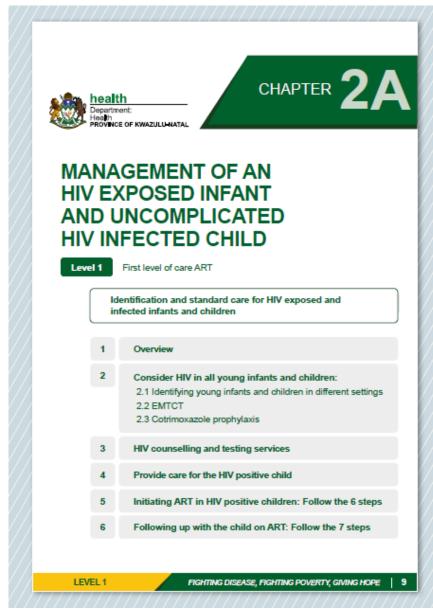
HIV Step-by-Step guide







HIV Step-by-Step guide



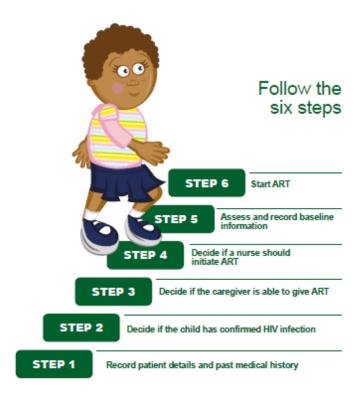
Overview of the HIV services for the uncomplicated young infant and child CONSIDER 2.1 Identifying young infants and children in different settings (using IMCI) HIV INFECTION 2.2 EMTCT IN ALL · Routine testing for HIV exposed infants YOUNG Infant prophylaxis for HIV exposed infants INFANTS AND 2.3 Cotrimoxazole prophylaxis CHILDREN (page 11) Tools: IMCI chart booklet and recording forms 3. HIV counselling and testing services HIV TESTING stage 1-7. Tools: Hand of safety and SERVICES Keeping my body healthy PROVIDE Tools: Disclosure assessment and plan, and **CARE FOR** Paediatric and Adolescent Clinical THE HIV Stationary **POSITIVE** CHILD Record patient details and past INITIATE medical history Refer to the 2. Confirm diagnosis next level of 3. Decide if mother can give ART care if indicated 4. Decide if Nurse can initiate ART in Step 4, see 5. Record baseline information Chapter 3 6. Give ART Tools: Paediatric and Adolescent Clinical Stationary Assess and Classify PROVIDE 2. Monitor progress on ART Refer to next **FOLLOW UP** 3. Provide ART CARE level of care 4. Provide other treatments if indicated see 5. Provide routine care Chapter 3 6. Counsel the caregiver Arrange follow-up care Tools: Paediatric and Adolescent Clinical Stationary



HIV Step-by-Step guide

SECTION 2A.05

05 Initiating ART in HIV positive children



SECTION 24 05

STEP 1

RECORD PATIENT DETAILS AND HISTORY



Take a comprehensive medical history and record the following information in the Paediatric and Adolescent Clinical Stationary.

1. Patient details:

Record the personal and demographic details of the patient.

2. Caregiver details:

- Record the personal and demographic details of primary caregiver.
- Record the personal and demographic details of secondary caregiver or contact person.

3. Past medical history:

Record:

- Allergies
- Mode of transmission of HIV infection
- ARVs prior to ART start date, including PMTCT prophylaxis
- ART transfer in details
- Disclosure status
- Past medical and surgical history, including immunisation status and nutrition status (update from RTHB)

Record in Paediatric and Adolescent Clinical Stationary



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Patient education material

We need to take special medicine for the strong germ. This medicine is called 'good night' medicine and it will put the strong germ to sleep. When the germ is asleep our soldier cells can be strong again and keep our bodies well.



There are some other things we can do to keep our soldier cells strong and healthy.

These are:

- · Eat lots of different healthy foods
- Take our medicine every day, like the nurse told us
- · Drink lots of water
- Rest and sleep
- · Exercise and play
- . Think about things that make us happy







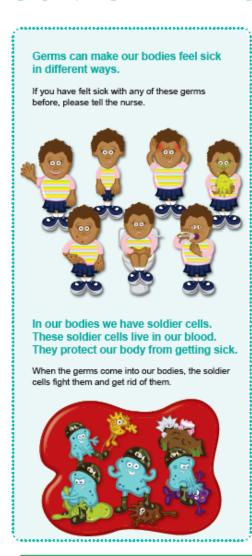




Inside our blood, we can have many different kinds of germs. These germs can make us sick.

Some of these germs are:











How can I help my child to have good adherence?

Talk to your child about their health and taking their medication (disclosure).

If your child is under 10 we can help you to use the correct words to describe their illness.

If your child is over 10 we can help you to name their illness and help your child to understand what is happening in their bodies and how the medication helps them to stay well.

Children have good adherence when they are told the truth and included in their health journey.

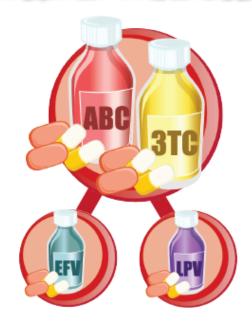
Talk to someone at the clinic if you are struggling with adherence or need help to talk to your child.

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Organisation	Area of Expertise	Webpage Address
Childrenf s In stitute	Child rights and law	www.ci.org.za
Childline South Africa	Child abuse Counselling	www.childline.org.za
Lifeline	Counselling	www.lifelinesa.co.za
Department of Social Development	Suspected Abuse reporting	www.dad.govza
The South African Social Security Agency (SASSA)	Child grants	www.sassa.gov.za
Department of Health	Guidelines Publications	www.doh.coza/health

031 266

012 400 2000

HELPING MY CHILD ADHERE TO MEDICATION







What is good adherence to medication?

Taking the right dose, at the right time, every single day, under the right conditions (for example, keeping the medication in the fridge, as prescribed by the nurse or doctor. We call this good adherence.

Take every dose:





How does medication help my child to stay well?

By taking medication, as prescribed, the strong germ will not be able to make copies of itself.

We can measure how many copies of strong germ are in your child's body. This is called viral load.

If your child has good adherence, the viral load will be low. Meaning that the medication is controlling the strong germ.

If the viral load is low your child's immune system (soldier cells) will become stronger and the body will be able to fight off other diseases, keeping your child well and healthy.

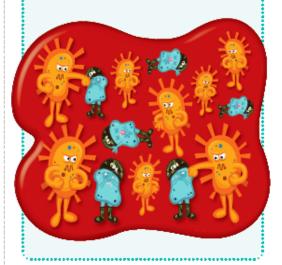
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What can happen if my child does not have good adherence?

The strong germ will make many copies of itself and your child's viral load will be high. This means that your child's soldier cells will be few. The body will not be able to fight other diseases and your child will become sick.

If your child misses to many doses, the medication will stop working. We call this treatment failure.

We may need to change your medication. This medication is harder to take and has more side effects.





Tips to remember

When giving medication:

- Give at the same time as daily activities, like a favourite TV show
- · Set alarms as reminders
- Use a diary and mark off when medication is taken
- Use a pill box
- · Use a reward system for your child
- Including your child in their health journey makes them learn responsibility for taking their own medication as they get older.

Should I give the medication with food?

Not all medication is the same. Here is the guide:

Medications without food:

- Lamivudine (3TC)
- Abacavir (ABC)
- Tenofovir (TDF)
- Zidovudine (AZT)
- Nevirapine (NVP)
- · Lopinavir Ritonavir solution

Medications with food:

Lopinavir Ritonavir solution

Avoid fatty foods:

· Efavirenz (Stocrin) - best at bed time

IMPORTANT REMINDER

Always ask the healthcare provider before taking any other medication!

Even natural or traditional medicine might not go well with medication.

Where must I keep the medicine?

- · Always keep medicine in a cool, dry and dark place
- · Avoid keeping medicine in the kitchen or bathroom
- · Some medicines need to be kept in the fridge:
- Kaletra solution

What side effects can you expect?

- Most children do not get side effects
- . The side effects differ from one ARV to another
- The most common side effects when starting ARV's include: diarrhoea, nausea, and vomiting these will clear up with time

Sometimes children can get more serious side effects, like:

- · Severe stomach pain
- · Fast or difficulty in breathing
- Pain in feet
- · Rash in the mouth and on the body
- · Severe vomiting and diarrhoea

Short term side effects:

- Dizziness, nightmares, drowsiness and confusion caused by Efavirenz, Stocrin
- Vomiting and Diarrhoea if this lasts more than two days or is severe bring the child to the clinic.

IMPORTANT REMINDER

All serious side effects should be managed by a doctor or nurse. If a child is experiencing any serious side effects, or fevers, take them to the clinic as soon as possible!

My Medicine and I

Giving medicine to Children







What medication will my child need?



In most cases a child will need at least 5 types of medication:

- · Multivitamin in the morning
- · Co-trimoxazole (Bactrim) daily
- A combination of 3 ARV medicines



Additional medicines:

- TB
- Deworming
- Vitamin A drops

What is Good Adherence?

Take every dose:



Everyday



3 Under

Under the right conditions



stored at the right

temperature etc)

What do I need to know?

- 1. The name of the medicine
- 2. When and how often to give of each medicine.
- How much of each medicine to give (this may change at almost every visit, based on your child's weight).

IMPORTANT REMINDER

Please make sure that your child is weighed at every clinic visit and recorded on the Road to Health Booklet.

How should I give the medicine to my child?



The amount of medication to give can be found on the label.

If the label states to give 2ml, as an example, you will need to:

- STEP 1: Place the tip of the syringe in the liquid medicine.
- STEP 2: Draw up the liquid until the plunger is in line with the correct number on the syringe e.g. 2.
- STEP 3: Flick the syringe to move any liquids to the top - then push the plunger down to remove these bubbles.
- STEP 4: Repeat step 1 and 2, if necessary (to make sure you have the right amount of liquid)

STEP 5: Give this amount to the child in their mouth e.g. 2ml

What are common questions?

What if my child vomits after I give the medicine?



- If the child vomits before 30 minutes of giving the medicine, give it again.
- If the child vomits after 30 minutes of giving the medicine - do not give it again until the next dose.

What if I forget to give the medicine?

For 12 hourly doses:

- If you remember before 6 hours give it
- If it is more than 6 hours skip the dose

For once daily doses:

- If you remember before 12 hours give it
- If it is more than 12 hours skip the dose

IMPORTANT REMINDER

Never give a double dose!

When is the best time to give the medication?

- · A time that suits you and your child's routine
- For twice daily doses give medication 12 hours apart or as close to 12 hours as possible



IMCI tools and materials

Electronic

IMCI

Develop and test with phased implementation

Align with updated guidelines and simplify

Pamphlets:

- Healthy lifestyle
- HIV disclosure
- How to take ARVs
- Adherence and Virological failure

Paeds &

Patient

adolescent HIV stationary

> education material

HIV Paediatric task team (KZN DOH):

- Step by Step guide for paediatric and adolescent HIV. KZN DOH intranet resource
- IMCI Chart Booklet updates: KZN 2017 adaption for KZN DOH intranet resource

Job aids:

- IMCI wall charts
- Recording forms

- IMCI wall charts updated/ created
- Public license
- KZN DOH intranet resource

Strengthen **IMCI** implementation

Update HIV component **Supervision**

3 day supervisors training

Supervision tools (DCSTs)

Training materials

- **PowerPoint** presentations created (3 day training)
- Used by RTC
- **KZN DOH intranet** resource



KZN paeds and adolescent HIV stationary

PAEDIATRIC & ADOLESCENT STATIONERY (0-15 YEARS)
Allergies None unknown Yes, specify:
health Department: Health PROVINCE OF KWAZULU-NATAL
Patient Name: Folder No:
Current PRE-ART Current ART Transfer Out Loct to Follow Up Deceased
General Strong Safety Wellness Germ Count Bloods

LONGITUI									
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KZN paeds and adolescent HIV stationary

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Date started: dd / mm /	yy_Car	nic		Date sta	rted: d	I I mm	l yy	_			
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General HIV education and healthy living (Use patent education tool f)											
ARV's Adherence plenning & demonstration of medicines (Use patient education tool)											
Other											
Sources of support for client (Specify and 5ck appropriate)			Caregiveried home visit? s	descent e	greed to	Name of worker:		nity health	Ce	regive	riadolescent support group?
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is the patent aware of their			_								
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General Health Status											
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KZN paeds and adolescent HIV stationary

4. IF A NURSE SHOULD INITIATE ART (NIMART)	
Other severe classifiaction: Yes No Weight < Skg: Yes	No Should ART be Yes No nurse initiated:
5. ASSESS AND RECORD BASELINE INFORMATION FOR ART INITIATI	ION
5.1. BASELINE NUTRITIONAL ASSESSMENT	
Weight (kg): Height/length (cm): Head circumference (cm):	MUAC (cm): BMI
CHECK FOR MALNUTRITION: All children < 5 years Lock at the care of the proje Weight for Neighburgh or BM Owders of both hat Weight gain unsatisfactory Locing weight Locing weight WEIGH WEIGH WEIGH WEIGH WEIGH WEIGH WEIGH WEIGH WEIGH	ALWAYS CLASSIFY Severe acute mainutrition with Medical complication Acute maintrion without medical Completion Moderate acute mainutition Not growing well and an emission rices Crowing well and an emission rices Crowing well and acute maintrions
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12.5cm or more <14.5cm or more > 18cm or more	
5.2. Assessment of Anaemia	
CHECK FOR ANALEMA Severe Palor Some Palor Figis, Hemosphich messured grid, Hemosphic messured	
5.3. TB RISK - All Children	
Previous TB History	TB Testing
Ever hed TB before: No Yes If yes: Tests Year ETB / PTB / Both Outcome	Date Result
Year E187718786th Outcome Gene Xpert dd	I mm I yy
Smear dd	I mm I yy
Culture / sensitivity dd	I mm I yy
X-ray dd	I mm I yy
	I mm I yy
Close TS contact Cough for 3 weeks Fever for 7 days NOT GROWING WELL	ALWAYS CLASSIFY
All children with High Mak of TB or risk of TB must have full TB assessment and be classified for TB. STEP 1: Penistent, rec-emitting couch or wherea for more than 2 weeks.	High risk or TB TB exposed Risk of TB Low risk or TB
STEP 1: Persistent, rot-entiting cough or wheate for more that 2 weeks. **Documental task of weight or areafinidary weight gain during the past 3 months (expectally first reporting to decoming together with food and/or instructions supplementation). **From energing for 14 days or more. STEP 2: SEND SHUTLAN OR GASTROY ASSPACE FOR EXPERT AND CULTURE: STEP 3: **DOA TIST***	Confirmed TB Probable TB Probable TB TB exposed TB styles DO A TSTmm
5.4. DEVELOPMENT SCREENING (Use chart in RTHB)	
Cen your child see?	No. Level of Care Occupational Therapist Physiotherapist Speech Therapist / Audiologist Other.
5.5. REPRODUCTIVE HEALTH Not applicable Reproductive assessm	ent done
is the patient currently pregnant: No Yes If yes, what trimester: 1st 2nd	d Srd Grev:Pere:
Pep amear result	Dete: dd / mm / yy
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Signs and Symptons of STI today?	
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IMCI tools and materials

Develop and test with phased implementation

Align with updated guidelines and simplify

Pamphlets:

- Healthy lifestyle
- HIV disclosure
- How to take ARVs
- Adherence and Virological failure

Electronic IMCI

Job aids:

- IMCI wall charts
- Recording forms

- IMCI wall charts updated/ created
- Public license
- KZN DOH intranet resource

Paeds & adolescent HIV stationary

Patient education material

Strengthen IMCI implementation

Supervision

- 3 day supervisors training
- Supervision tools (DCSTs)

HIV Paediatric task team (KZN DOH):

- Step by Step guide for paediatric and adolescent HIV. KZN DOH intranet resource
- IMCI Chart Booklet updates: KZN 2017 adaption for KZN DOH intranet resource

Update HIV component

Training materials

- PowerPoint presentations created (3 day training)
- Used by RTC
- KZN DOH intranet resource

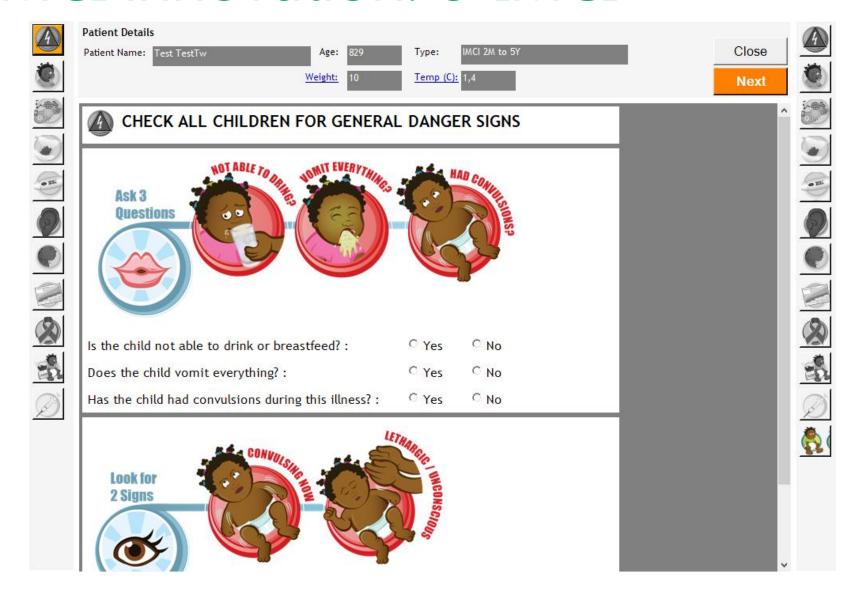




WHY?

- ↑case finding for HIV, TB, malnutrition.
- Strengthen case management:
 - > **Decision support**: Guidance throughout the consultation.
 - > Reduce risk of classification and treatment errors.
 - ➤ Facilitate **completeness** of assessments and treatments for children and prevents skipping steps during case management.
- Strengthen linkages between communities and facilities.
- Strengthen and simplify data quality and reporting.

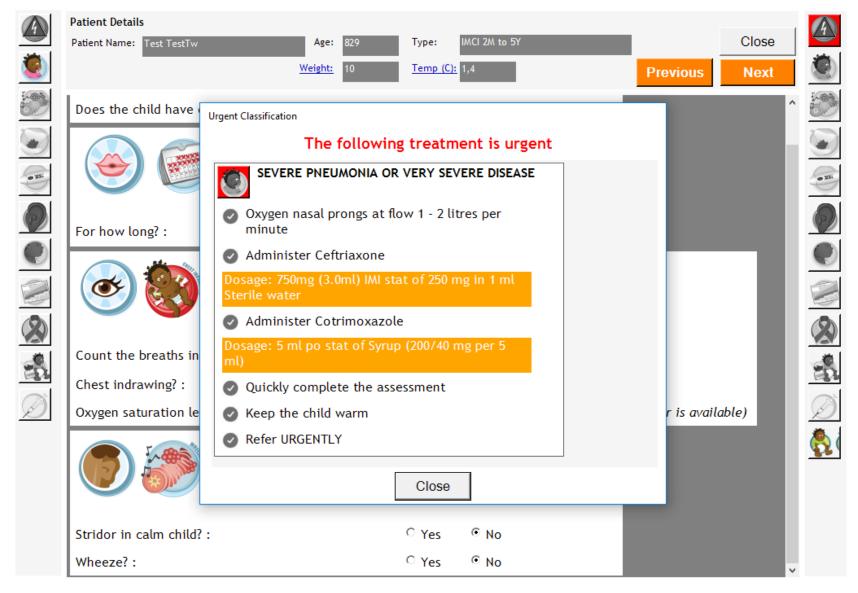


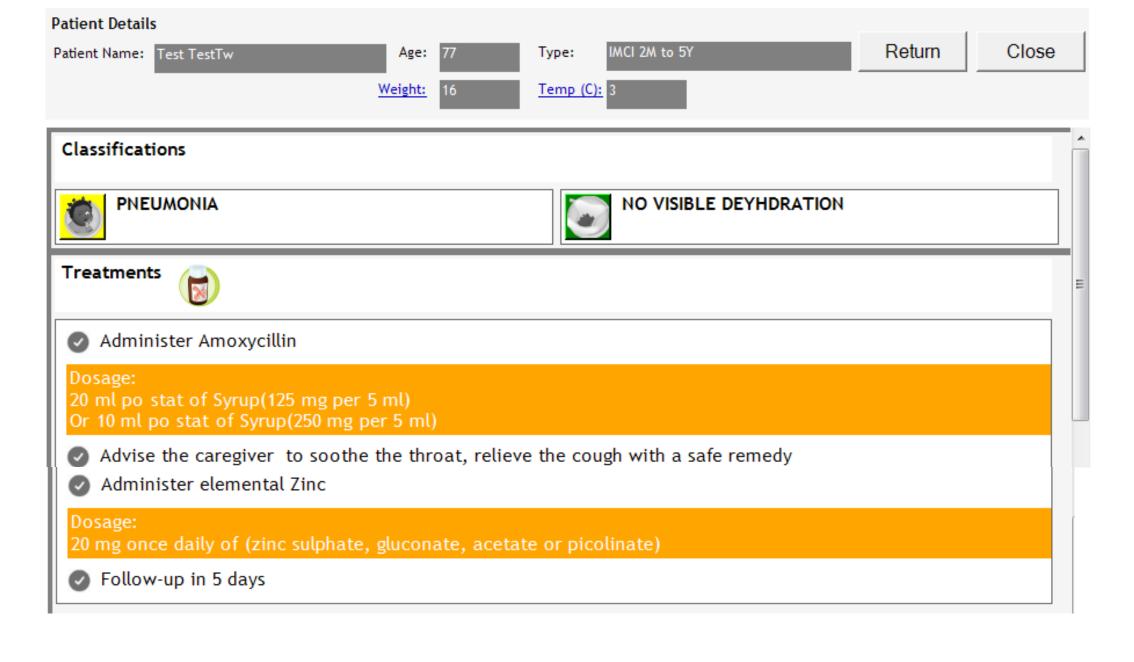














Thank You



- NDOH
- KZN Child Health Department and Nutrition
- ILembe DOH
- ID department at UKZN
- ELMA
- Zoë-life
- Virtual Purple
- Health Enabled
- PEPFAR/CDC